## PLEASE PRINT CLEARLY

**DENTAL** 

## ANTHEM BLUE CROSS AND BLUE SHIELD **ENROLLMENT GROUP NAME DENTAL ADMINISTRATION OFFICE** APPLICATION 555 MIDDLE CREEK PARKWAY MS425 **GROUP NUMBER EFFECTIVE DATE** COLORADO SPRINGS, COLORADO 80921-3634 MO. DAY YEAR DENTAL PLAN SELECTED (FOR GROUPS OFFERING MORE THAN 1 PLAN) Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. I WISH TO: □ENROLL/NEW □ADD DEPENDENTS □ REMOVE DEPENDENTS □ ADDRESS CHANGE □ COBRA **EMPLOYEE INFORMATION** FIRST NAME AND M.I. LAST NAME MALE FEMALE SOCIAL SECURITY NUMBER ADDRESS (STREET) DATE OF BIRTH MO YEAR DAY CITY STATE ZIP CODE DAYTIME PHONE NO. MARITAL STATUS ☐ MARRIED □ SINGLE DATE DATE OF EMPLOYMENT MO. DAY YEAR # OF HOURS THAT YOU WORK PER □ DIVORCED JOB TITLE TELEPHONE NUMBERS HOME WORK MO. DAY YEAR □ SEPARATED WEEK ☐ WIDOW (ER) TYPE OF DENTAL COVERAGE SELECTED ☐ EMPLOYEE AND CHILDREN ☐ EMPLOYEE AND SPOUSE ☐ EMPLOYEE AND FAMILY ☐ EMPLOYEE ONLY ☐ EMPLOYEE AND ONE CHILD **DEPENDENT COVERAGE INFORMATION** Check below RELATION (√) Check if if dependent Name: (First, M.I., Last name if different) (Spouse, son Social Birthdate is over 23 included Security Number on tax return daughter, Mo Day Yr List additional children on separate sheet and attach to application. Full time Disabled stepson, etc.) student before age 23 SELECT ONE ❖ جہ\_ Yes No Yes No □ ADD / DELETE □ Yes No Yes No □ ADD / DELETE □ No Yes No ☐ ADD / DELETE ☐ Yes No Yes No ☐ ADD / DELETE ☐ Yes No Yes No □ ADD / DELETE □ $\Box$ Yes No Yes No □ ADD / DELETE □ OTHER DENTAL INSURANCE INFORMATION COB Are you, your spouse, or dependent child(ren) covered by any other dental plan that will remain in effect? ☐ Yes ☐ No If yes, please complete the following: Whom does it cover? You ☐ Your Spouse ☐ Your Children Birthdate Day Insurance Company Name of Insured \_ Name and Address Policy (or Identification) Number Group Number **CERTIFICATION (THIS SECTION MUST BE READ AND COMPLETED)** I and my agent (if applicable) certify that I have read, or have had read to me, the completed application (including the CERTIFICATION section), and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy. I understand that Anthem Blue Cross and Blue Shield may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. When false or misleading information is discovered, Anthem may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application, if the discovery is made within two years after such effective date. Any claims paid during the periods when the coverage was not in force will be deducted from any premium refund. If the amount of benefits paid by Anthem exceeds the premium paid, I agree to refund any excess amount to Anthem. Employee Signature Daytime Phone Number Date

**PAGE 1 - ANTHEM COPY** 

Your signature is required before coverage can become effective.

PAGE 2 - GROUP COPY

PAGE 3 -EMPLOYEE COPY WITH INSTRUCTIONS ON BACK

Date

Daytime Phone Number

Agent/Broker Signature